VALUES, RATIONALITY, AND POWER

CRITICAL MANAGEMENT STUDIES

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VALUES, RATIONALITY, AND POWER: DEVELOPING ORGANIZATIONAL WISDOM

A Case Study of a Canadian Healthcare Authority

BY

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Chapter 1

Study Overview

How do we create organizations that act wisely? Can we even put 'organization' and 'wise' in the same sentence without irony? Through this study, I hope to demonstrate that organizations can act wisely, and more importantly, we can help them do so. In this investigation, I performed an embedded, single case study (Yin, 2014) within the British Columbia (BC) Health Authority, a regional health authority situated in a major metropolitan area of BC, Canada. The specific case was the implementation of the Seniors Programme, a pilot project for the community-based care of seniors who are not yet frail but are at risk of becoming so.[1] This single case study drew on a narrative analysis of interviews I had with programme stakeholders as well as a textual analysis of documents produced through the programme's implementation.

Why the focus on a Canadian Health Authority? Canadian spending on healthcare is one of the highest in the Organization for Economic Co-operation and Development (OECD), yet its performance outcomes on many measures are worse than OECD averages (Conference Board of Canada, 2012; 'OECD Health Data 2014', 2014). The causes of this are complex and multifactorial. One piece of the puzzle, however, is the healthcare system is composed of multiple groups, each in possession of considerable power, each representing different value positions and self-interests, and each of whom must work together and implement decisions for the betterment of patient care and society (Simpson, 2012). Decision-making in such pluralistic organizations can be complicated and fraught with political strife, making wise decisions challenging to implement (Bucher & Stelling, 1969; Scott, 1982). According to Simpson (2012), Canadian healthcare costs with their current growth trajectories challenge the sustainability of the system. Since other countries can achieve more value for their healthcare dollar than Canada, there is a need to develop our understanding of how to facilitate wise decision-making to enable a financially viable healthcare system meeting the values espoused in the Canada Health Act.

In the following sections, I lay out an overview of this study and its findings. I open with an introduction to organizational wisdom and my main constructs of values, rationality, and power. Then, I summarize the theoretical frameworks on

[1]To maintain confidentiality of my interview subjects, I have changed the names of all organizations and programmes.

which I built this study and my methods, followed by an overview of my results. I close this chapter with a preview of the key learning uncovered in this study.

1.1. Introduction to Organizational Wisdom, Values, Rationality, and Power

What does wisdom mean? How do we study it? How do we develop the wisdom of our society's establishments? I explore answers to these questions in Chapter 2. In brief, wisdom is a social construct, which leads to diverse conceptualizations of it (McNamee, 1998; Pitsis & Clegg, 2007; Sampson, 1998). We see wisdom in those capable of balancing many forms of knowledge and values to reach a common good over the long- and short-term (Jordan & Sternberg, 2007). Organizations are collections of individuals working together, creating additional challenges to wise action. Overcoming these challenges, however, gives individuals useful tools to navigate the wild complexity of organizational reality (Vaill, 1998, 2007), avoid costs of foolish mistakes (Beyer & Nino, 1998), and capture unique opportunities (Chia & Holt, 2007).

Kessler and Bailey (2007a) stratified organizational wisdom along four levels of analysis: individual, teams, organizations, and strategy. Individually, people exhibit practical wisdom by focusing on contexts rather than applying general rules. They use multiple forms of rationality and values to navigate complexity (Flyvbjerg, 2001). In teams, wise groups bring a diversity of opinions and values into dialogue to create effective action (Boyatzis, 2007). Organizationally, wise leaders develop the ability to learn on the fly (Vaill, 1998, 2007) and improve long-term viability by balancing the needs of the broadest range of stakeholders (Conger & Hooijberg, 2007). Strategically, wisdom is the use of knowledge and experience to act in a manner appealing to different environmental stakeholders (De Meyer, 2007). Three themes of wisdom arose from the literature: (1) values guide wise action, (2) knowledge is required, but insufficient for wise action, and (3) wisdom is action-oriented, requiring individuals to exercise power in order to act.

In Chapter 3, I review the literature on two of these three themes: values and rationality. Values are the ends we find worth achieving and inform the means we are willing to employ to achieve those ends (Townley, 2008b). Beck Jørgensen and Sørensen (2013) have classified several value constellations expressed in the public sector. They show that Canada has emphasized several of these values in its 'Values and Ethics Code for the Public Service', and the Canada Health Act embodies a number of these values. These values are diverse and are at times incompatible, if not incommensurable with each other (De Graff, Huberts, & Smulders, 2014). Workers in the public sector use several tactics to address these value conflicts (De Graff et al., 2014; Oldenhof, Postma, & Putters, 2014).

Rationality is the basis of social coordination and provides the foundation, defence, and explanation of action (Townley, 2008b). Its relation to action

intertwines it with power (Flyvbjerg, 1998). Townley (2008b) identified three faces of rationality. *Disembedded rationality* assumes the existence of objective knowledge that is discoverable through the application of several techniques. *Embedded rationality* argues that an observer can only consider rationality from the context of the situation. *Embodied rationality* maintains that rationality is experienced viscerally through our bodies, emotions, and psyche. When individuals work together, they engage in forms of collective rationality. When individuals and groups bring multiple rationalities to bear on a subject, using disembedded rationality to inform embedded and embodied rationality, practical reason becomes achievable.

The third theme of wisdom is its action-oriented nature. Acting requires the exercise of power. Chapter 4 presents my review of power research. Hardy and Clegg (1996) identified two categories of power research. The first took a critical view of power that considered power from the perspective of classes. This view evolved into the four dimensions of power conceptualized by Lukes (2005). The first dimension considered how to get others to do what you want. The second explored how power suppressed conflict by preventing discussion on specific topics. Power's third dimension explained how it prevented conflict through the legitimation of authority. The fourth dimension viewed power as social networks and discourses encompassing all members of society. Hardy and Clegg's (1996) second branch of power research took a structural functionalist direction observed through a managerial perspective. Researchers working on this branch saw power as hierarchical in that the organization allocated power according to one's position. Workers, however, maintained the capacity to resist this hierarchical order through various means. Fleming and Spicer (2014) presented an organizing framework for power research. They mapped power along two axes. The first axis listed the faces of power. These included episodic uses of power such as coercion and manipulation and systematic power such as domination and subjectification. The second axis identified sites of power. These sites included power in, through, over, and against organizations.

Power is intertwined with values and rationality. I argue that systematic power influences the values people hold. Moreover, I further hypothesize that when values conflict, individuals exercise power to promote the values they pursue. Power exhibits its relation to rationality through influencing what individuals debate and how they construct their arguments (Townley, 2008b). Additionally, power structures adopt the rationalities that support them (Flyvbjerg, 1998; Townley, 2008b).

My research setting is a healthcare organization. Such organizations are pluralistic (Bucher & Stelling, 1969; Scott, 1982). Pluralistic organizations consist of specialized, highly trained groups with different objectives and complex power relations between them. Though this organizational structure effectively deals with work that is complex, uncertain, and important, it can lead to environments where political infighting dominates (Scott, 1982). The complexity of pluralistic organizations makes them a great test bed to study the dynamics of values, rationality, and power.

1.2. Introduction of Theoretical Frameworks and Research Questions

I have embedded this study in the philosophical school of critical realism. As I describe in Chapter 5, critical realism possesses a stratified ontology wherein social structures, such as power relations, simultaneously constrain and enable individuals' actions. These actions produce and reproduce social structures and, if these actions are observed, create experiences (Bhaskar, 1978). In this book, I classify values, rationality, and power as relevant social structures for study. I apply a research approach developed by Flyvbjerg (2001) called 'phronetic research' (PR). Though I explore PR deeply in Chapter 5, I will briefly introduce it here.

As Flyvbjerg (2001) described it, PR is an approach aimed at developing the practical wisdom of society's institutions. Its underlying assumption is that through an understanding of how rationality and power influence each other, actors can increase the capacity for value-rationality in institutions (Flyvbjerg, 2001). Through the application of a PR approach, this study contributes to our understanding of how to develop organizational value-rationality. PR focuses on power because power influences the creation of knowledge to justify its actions and mechanisms of control (Flyvbjerg, 1998). Moreover, PR emphasizes creating knowledge that allows people to facilitate change (Flyvbjerg, Landman, & Schram, 2012; Schram, 2012). With this understanding, Flyvbjerg (2001) listed four questions for researchers to use when applying a PR approach: (1) Where are we going? (2) Is this desirable? (3) With each decision, who gains, who loses, and through what power mechanisms? (4) What should be done? I have developed my study's research questions, shown in Table 1.1, around these four questions.

Table 1.1. Research Questions.

PR Questions Addressed by the Research Question	Research Questions
(1) Where are we going? (3) With each decision, who gains, who loses, and through what power mechanisms?	How did power affect the process of developing and implementing the Seniors Programme in the BC Health Authority?
(2) Is this desirable?	Did power wielded by stakeholders of the Seniors Programme result in organizational actions in keeping with the values of Canada's healthcare system?
(4) What should be done?	No research question *per se*, but recommendations at the end address the final PR question.

You will notice that I have introduced a value judgment in my second research question: 'Did power wielded by stakeholders of the Seniors Programme result in organizational actions in keeping with the values of Canada's healthcare system?' I have prioritized the values of Canada's healthcare system and set them as the litmus test for wise action. Is this appropriate? As I will discuss when reviewing the literature on organizational wisdom, what people consider wise is embedded in systems of power – that is, whether someone judges an act as wise depends on who is doing the judging (McNamee, 1998; Pitsis & Clegg, 2007; Sampson, 1998). Flyvbjerg (2001) recognized this, arguing there exists no objective definition of which acts are wise. Instead, individuals act 'wisely' by determining what is ethically practical within a social context. The social context of my research setting is a Canadian healthcare system. Following this logic, then, the litmus test of wise action for stakeholders of the Canadian healthcare system are the values of the Canadian healthcare system.

1.3. Summary of Methodology

In Chapter 6, I describe my methodology. I performed an embedded case study on the implementation of the Seniors Programme. The Seniors Programme was a pilot project implemented through a collaboration between health authorities in BC and Nova Scotia (NS) and the Foundation, a not-for-profit organization focused on the development and spread of innovative healthcare solutions. The purpose of the Seniors Programme was to develop an intervention that paired seniors with appropriate community resources to facilitate lifestyle choices that delayed the progression of frailty. To implement the Seniors Programme, the BC and NS health authorities sent individuals to participate in a training programme the Foundation ran to teach administrators how to develop, apply, and spread innovations. Compounding the difficulty of developing an intervention to delay frailty, the BC Health Authority experienced turnover at the level of the chief executive officer (CEO) that threatened organizational commitment to the programme.

My data included texts and semi-structured, open-ended interviews of key individuals involved in developing and implementing the Seniors Programme. On this data, I performed a narrative analysis as per Feldman, Sködberg, Brown, and Homer (2004). I coded the data for values, rationality, and power. PR research justified a qualitative approach such as the ones I used (Flyvbjerg, 2001). These methods can provide detailed situational information needed to understand the interplay of values, rationality, and power within my research setting (Flyvbjerg, 2001). Case studies allow the researcher to observe human behaviour and values within social contexts (Flyvbjerg, 2001, 2004, 2006a, 2006b). Narrative analyses are an effective means to understand the underlying meaning of discourses (Eriksson & Kovalainen, 2008; Flyvbjerg, 2001, 2004, 2006b) and provide the same data individuals operating within organizations use to evaluate their own reality (Pentland, 1999).

1.4. Overview of Results

Chapter 7 presents my analysis of the values the developers of the Seniors Programme pursued. These included public interest, sustainability, innovation, effectiveness, self-development of employees, accountability, dialogue, user orientation, and spread of innovation. My data showed that not all values were equal: some were what Dahl and Lindblom (1953) called 'prime values' (ends in themselves), while others were instrumental values (means to achieve those ends). These values were consistent with the values espoused in the Canada Health Act, demonstrating that the development of the programme was within the remit of the healthcare system. The data showed the link between values, rationality, and power. My interviewees often noted how vital it was that the programme was 'evidence-based'. That is, they joined the programme not only because it pursued relevant values but because it did so using a form of rationality they venerated. Moreover, the programme only gained organizational reality through individuals' exercise of power.

Despite the alignment of values between the Seniors Programme and the Canada Health Act, I show in Chapter 8 that some vice presidents (VPs) within the BC Health Authority resisted the development of this programme. Interestingly, these VPs seemed to share prime values with the developers of the Seniors Programme. Why, then, were they unsupportive of it? Conflicts across two parameters caused their resistance. First, though they shared prime values, instrumental values differed. VPs pursued public interest through the value robustness (i.e. managing acute care and decongestion of hospitals), whereas the programme developers pursued public interest through innovation (i.e. creating the Seniors Programme to reduce frailty). Second, though they shared the prime value of public interest, the time frame VPs operated in differed from the programme developers: VPs managed acute care in the present; the programme developers were seeking long-term solutions. The VPs did not disagree with the aims of the Seniors Programme. Instead, they were hesitant to devote resources to a programme utilizing different instrumental values and operating in different time frames.

VPs exercised their resistance through use of episodic power, most notably manipulation. For example, they discouraged their staff from working on the Seniors Programme and kept the programme from appearing on meeting agendas where developers could present their work. Nonetheless, developers found ways to exercise their power in the organization to meet with VPs. Through the emphasis of shared prime values and effective use of multiple forms of rationality, they got senior managers interested and supportive of the programme. They built on this support throughout the life of the Seniors Programme by presenting positive results and by carefully managing communication within the BC Health Authority to embed their programme within an incumbent community of senior care initiatives. Later, programme developers leveraged this support to protect the programme during periods of CEO turnover.

The CEO of the BC Health Authority initiated the Seniors Program. He left the organization partway through the program's implementation. Despite his

departure, the Seniors Programme survived, and a subsequent CEO became its new executive champion. This did not happen by accident. As I describe in Chapter 9, from the program's earliest conception, the first CEO acted to bind his organization to the Seniors Programme despite initial resistance from his VPs. These actions included recruiting project champions who possessed passion, drive, and political savvy to move the project. He then used a variety of bureaucratic structures to protect those champions from the politics of the organization. He further used various forms of bureaucratic rationality to commit his organization to a national collaboration to develop the program, which subsequently created external allies fostering the Seniors Program's survival.

Chapter 10 presents my analysis of the different forms of rationality individuals used throughout the Senior Program's life. A specific form of disembedded rationality, named technocratic rationality, dominated. This rationality assumes there is a best way of accomplishing a task revealed through application of the scientific method. Though technocratic rationality dominated, individuals used various forms of rationality. Sometimes the use of multiple rationalities added benefits. For example, when designing the intervention the Seniors Programme would implement, programme developers combined technocratic rationality with contextual (i.e. cultural) rationality, an embedded rationality. Technocratic rationality informed what the science said about how to prevent frailty, whereas contextual rationality informed how best to engage seniors to partake in those activities.

Different rationalities did not always complement each other. Recall that the Seniors Programme was a collaboration between BC and NS health authorities. These regions possessed differences in population and healthcare administration. That is, contextual rationalities differed between the regions. These differences prevented a single approach to the Seniors Program, thus undermining pure technocratic rationality. The developers attempted to reconcile this conflict by establishing high-level principles for the intervention (i.e. technocratic rationality) while allowing each region to modify the implementation of those principles (i.e. contextual rationality). Likewise, the BC working group undertook a similar reconciliation when applying the intervention to BC-based seniors. They had coaches apply an evidence-based intervention (technocratic rationality), which coaches then modified to the individual needs, limitations, and comfort level of senior participants. This individualization represented body rationality, which is a form of embodied rationality.

The developers also engaged in acts of defining rationality, a form of episodic power. For example, they defined the patient population the Seniors Programme targeted. This act pitted technocratic rationality against body, emotional, and contextual rationalities. In short, the scientific literature led to a name that seniors found negative and distasteful. Likewise, they created the program's vision statement, 'Age well, die fit'. Though this vision captured what the literature said was possible, it conflicted with contextual and emotional rationalities because it broke the taboo of healthcare professionals speaking about death. Throughout the life of the Seniors Program, technocratic rationality was a dominant rationality, and it bumped heads with several other rationalities. In each

case, the rationality of the group that held power in a particular context prevailed.

In Chapter 11, I analyse how individuals reified power through the Seniors Program's life. I demonstrate how shared values motivated people to overcome structures constraining action. Importantly, my data showed how individuals used bureaucratic rationality to give power structure and reality. I also assessed how individuals exercised empowerment using contextual and body rationalities. The data demonstrated that a critical action the developers took to avoid conflict and build power relations was the careful management of communication. Finally, I explored how managers created organizational structures that protected workers from political turmoil, allowing them to focus on the work needed to bring the Seniors Programme to life.

In Chapter 12, I explore the developer's intentions to spread the Seniors Programme nationally. I assessed how important the intent to spread was to the people involved in the Seniors Programme and consider why individuals employed to administer healthcare to a localized region were interested in national spread. The data showed that my interviewees only viewed the Seniors Programme as a qualified success. They felt their results were positive – their intervention meaningfully delayed the onset of frailty. My interviewees also felt they learned much from the experience of participating in a multi-institution collaboration to create the program. National spread, however, was not happening at the time I wrote this book. Instead, spread was limited to the region administered by the BC Health Authority. The programme was alive, but more limited than they had hoped.

Thus, I explored the structures constraining spread of the Seniors Program. I learned that health authorities were risk-averse. They were responsible for managing acute care, often under conditions of strained resources. This created an environment of risk aversion. When the health authority made a mistake, people may die. Consequently, health authorities were hesitant to experiment with innovations. Structural constraints also hampered spread. For example, fee codes failed to compensate for some of the activities required of physicians implementing the Seniors Program. In the absence of a fee code, doctors were unable to bill for the work they needed to do to implement the Seniors Program's intervention, thus constraining spread. Similarly, if other healthcare professionals, such as nurses and physiotherapists, could offload some of the work from physicians, the issue of fee codes would become moot. The way BC structured primary care, however, precluded such tight integration of healthcare professionals. These constraints worsened as individuals sought to spread the programme nationally because each province delivered healthcare differently, meaning the challenges would-be spreaders faced differed across the country. Moreover, my interviewees identified that the difficulty of managing a healthcare region pulled at managers' attention, strained their resources, and sapped their energy. Sites may simply lack the resources of time, personnel, funding, and passion to take on something new due to the daily pressures they faced. The intensity of managing over-crowded hospitals day after day led to fatigue and an inability to absorb new programs.